

	STAFF USE ONLY
Sent on:	
Return by:	
Patient Name:	
Medical Record #(MRUN):	

Application for Gillette Assistance Program

Please complete the following application and return with ALL requested information. Applications with incomplete forms and/or missing verification(s) will not be considered. You may mail your application to:

Gillette Children's Specialty Healthcare Attn: Charge Integrity—GAP Internal Zip #010609 200 University Ave. E. St. Paul, MN 55101

Or you may fax it to: 651-325-2174.

If you have questions, please call 651-325-2177. You may also email financialassistance@gillettechildrens.com.

BEFORE YOU SUBMIT YOUR APPLICATION										
ü Sign and date applica	tion									
ü A copy of your most red	ent federal	income tax retur	n,							
with all schedules, must be in	cluded with	the application.								
Black out ALL Social Security numbers and bank account numbers										
		API	PLICAN	T INFORMATI	ON					
Responsible						Date	of			
Party/Guarantor										
Street										
Address										
City					State			ZIP		
Phone			Email	<u> </u>						
Marital Status:	Spouse's Name:				Date of					
DEPENDENT INFORMAT	ION					D. L.	1.		NII II D II 10	
Name			Date of Birtl	h	Relationship to Guarantor			Gillette Patient?		
Total Number in Househol	d:									

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EMPLOYMENT AND INCOME INFORMATION										
Applicant	□ H	☐ Homemaker				□ Unemployed				
Applicant	Retired	□ Disabled								
Name of Employer	Gross Mo	nthly Income			Seasonal?					
How Often Are You P	aid?	y 🗆 Biwe	ekly	Twice a Month		Monthly	□ Other			
Shalled	Employed		□ Homemaker			□ Unemployed				
·	Retired	□ D	sabled							
Name of Employer			Gross Monthly Income				Seasonal?			
How Often Are You P		y 🗆 Biwe	ekly	Twice a Month		Monthly	□ Other			
OTHER SOURCES OF INCOME										
Type of Income			Amoun	İ	How Often?					
Social Security/Disab										
Pension/Retirement I										
Alimony, Maintenance										
Government Assistan	ce									
Interest/Dividends										
Other										
INSURANCE INFOR	MATION									
Do You Have Current		Name of Ins	ıranco							
Medical Insurance			insurance							
Coverage?		Company								
Policyholder Name				Policy Number	•					
Name of Secondary I	nsurance Company (If	Applicable)								
Policyholder Name	Policy Number									
Have You Applied for	Medical Assistance?		If Ye	s, When Did Yo	ou Ap	ply?				
*IF YOU WERE DEN	ED MEDICAL ASSIS	TANCE, PLEA	SE PROVIDE	A COPY OF YO)UR I	DENIAL LET	TER			
other program-related purpos determined at its sole discreti	ion I have provided is subject es. I also understand that that on. I certify that all the above i	my application is sub nformation is true and	ect to the guideline correct.	s of Gillette Children's	s Speci	alty Healthcare a	nd that eligibility will	be		
I/We hereby supply Gillette Children's Specialty Healthcare with federal and state records of employment and income history, including State Employment Agency records. This authorization applies only to this transaction and continues in effect for one (1) year unless limited by state law, in which case the authorization continues in effect for the maximum period allowed by law, not to exceed one (1) year. A photographic copy of the authorization (i.e., the signature(s) of the undersigned) may be accepted as the original and may be used as a duplicate original.										
Signature					D)ate				
Spouse's Signature					D	ate				

Submit this application with ALL requested information. Incomplete forms will not be considered. Tax information must have your tax preparer's information OR be signed by the taxpayer(s). You will receive a letter notifying you of Gillette Children's Specialty Healthcare's decision to approve or deny your request for assistance. Should your application be denied, you may apply again if your financial status changes.